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IN THE

Supreme Court of the United States

October Term, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

MARIO M. CUOMO, ET AL.,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF FOR PETITIONERS MARIO M. CUOMO, ET AL.

G. OLIVER KOPPELL
Attorney General of the
State of New York
Attorney for Petitioners
Mario M. Cuomo, et al.
120 Broadway
New York, New York 10271
(212) 416-8707

JERRY BOONE
Solicitor General

ANDREA GREEN
Deputy Solicitor General

JANE LAUER BARKER
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General

**Counsel of Record*

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974 ("ERISA") preempts a state law which sets hospital rates for all patients, without regard to whether a patient is an ERISA plan participant, but which may have the effect of raising the cost of providing hospital care to some ERISA plans?

2. Whether ERISA preempts a state assessment on health maintenance organizations ("HMOs") which may result in increased cost to ERISA plans that purchase HMO services?

PARTIES TO THE PROCEEDING BELOW

In addition to the petitioners listed in the caption, the following parties are petitioners in this Court: Mark Chassin, M.D., in his official capacity as Commissioner of Health of the State of New York; Salvatore R. Curiale, in his official capacity as Superintendent of Insurance of the State of New York; Michael J. Dowling, in his official capacity as Commissioner of Social Services of the State of New York; and G. Oliver Koppell, in his official capacity as Attorney General of the State of New York.*

In addition to the respondents listed in the caption, the following parties are respondents in this Court: The Health Insurance Association of America; the American Council of Life Insurance; the Life Insurance Council of New York, Inc.; Aetna Life Insurance Company; Aetna Health Plans of New York, Inc.; Mutual of Omaha Insurance Company; Union Labor Life Insurance Company; Professional Insurance Agents of New York, Inc. Trust; New York State Health Maintenance Organization Conference; Health Services Medical Corporation; MVP Health Plan; Wellcare of New York; Mid-Hudson Health Plan; Oxford Health Plan; Capital District Physicians Health Plan; Choicecare Long Island; Independent Health; Travelers of New York; Physicians Health Services; Preferred Care and U.S. Healthcare.

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* Michael J. Dowling succeeded Mary Jo Bane as Commissioner of Social Services on June 30, 1993. G. Oliver Koppell succeeded Robert Abrams as Attorney General of the State of New York on December 30, 1993. Both are automatically substituted pursuant to Fed. R. App. P. Rule 25(d).

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BRIEF FOR PETITIONERS MARIO CUOMO, ET AL.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit is reported at 14 F.3d 708 and reproduced at JA 30-65.[1] The memorandum opinion of the United States District Court for the Southern District of New York is reported at 813 F. Supp. 996 and reproduced at A-63 to A-90.

JURISDICTION

The Court has jurisdiction pursuant to 28 U.S.C. § 1254(1). The judgment of the court of appeals was entered on October 25, 1993. Subsequently, the court of appeals granted a timely petition for rehearing and issued an amended opinion which was entered on January 14, 1994 (JA30-65). A petition for writ of certiorari was filed on March 10, 1994.

STATUTES INVOLVED

The federal statute involved is the Employee Retirement Income Security Act of 1974 ("ERISA"), § 514(a),(b)(2)(A), 29 U.S.C. § 1144(a),(b)(2)(A). The subsections are reproduced at A-99. The New York statute involved is the New York Public Health Law § 2807-c (McKinney 1993). The relevant subsections are reproduced at A-101 to A-113.

STATEMENT OF THE CASE

This case raises issues about the extent to which ERISA preempts the authority of the states to regulate in the health care field, an area of critical state concern. The Second Circuit Court

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[1] References to the joint appendix filed with this brief are cited as (JA ___). References to the joint appendix filed with the petition for a writ of certiorari are cited as (A-).

of Appeals held that three different, but related, New York State laws, which set hospital rates and impose an assessment on those HMOs which do not enroll a sufficient number of Medicaid recipients, are preempted because they may increase the cost to some ERISA plans of providing health care benefits.

New York contends that ERISA does not preclude it from regulating in the health care field in a manner which treats ERISA plan participants like any other consumer of health care even though as a result of the state laws, some, or even all, ERISA plans may pay more than they otherwise would for the medical goods or services that they purchase. Any other result would confer upon ERISA plans a charmed existence which would exempt them from generally applicable state laws solely because the laws may increase the cost of providing benefits.

A. History of Hospital Rate Regulation In New York State

Prior to the 1960s, New York did not regulate hospital rates. It was common practice for hospitals to negotiate rates with Blue Cross plans that were less than their published charges (JA 161-2). This was known as the "charge differential." The differential reflected the value to the hospitals of prompt and guaranteed payment by Blue Cross plans and recognized the community purpose served by them (JA 162).

By the late 1970s, federal and state cost control laws regulated the rates which hospitals billed patients covered by Medicare, Medicaid, Blue Cross plans, and HMOs. To ensure adequate revenue, hospitals billed patients covered by other payors, including commercial insurers, rates which were 25% to 40% higher than those paid by the regulated payors (JA 149).

In 1983, New York enacted a reimbursement system which set hospital rates for all payors. Hospitals had to bill patients covered by Medicaid, Medicare, HMOs and Blue Cross plans a uniform per diem rate (JA 150). They had to bill all other patients, including those covered by commercial insurers and self-insured groups, or "charge payors," at uniform rates that did not exceed

115% of the Blue Cross rate (JA 150). As a result, the hospital bills of patients covered by charge payors, who had paid 25% to 40% more than Medicaid, Blue Cross or HMO patients, decreased by 8% to 18%.

Charge differentials in favor of Blue Cross and HMOs are justified by cost savings to hospitals and positive social policy outcomes (JA 161-2). The principal cost savings accrue from prompt payment which provides working capital to hospitals and saves them money by reducing collection costs. The positive social policy outcomes include insurance coverage practices, most notably open enrollment and community rating, which make health insurance more available.[2] States in which insurers utilize these practices have between 20% to 30% fewer uninsured persons than the national average (JA 202). New York, in particular, has 20.8% fewer uninsured persons than the national average (JA 203). Studies undertaken by New York in 1958, 1965, 1980, and 1984 concluded that Blue Cross (and to a lesser extent HMOs) were the exclusive, or dominant, payors with these practices (JA 161-163). Blue Cross provides interim advance payments to hospitals, a practice even more advantageous to hospitals than prompt payment (JA 162). Blue Cross utilizes open enrollment and community-rates its small group market (JA 164). In 1984, a legislative report found that Blue Cross had been, and was, the only payor to offer individual and small group policies, without underwriting, at community-rated premiu[illegible]nd that it did so for over five million people in New York State (Exhibit "B" to Anderman Affidavit). In addition, the report noted that Blue Cross provided Medicare supplemental insurance at community-rated premiums to over one million New Yorkers. HMOs provided open enrollment to small groups of five or more and community rate their subscribers. N.Y. Comp. Codes R. & Regs.

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[2] Open enrollment is the practice of offering coverage to any person without regard to prior illness, physical condition, age or sex. Community rating is a methodology in which the premium for all persons covered by a policy form is the same based upon the experience of an entire pool of risks covered by that policy form without regard to age, sex, health status or occupation (JA 200).

tit. 10 § 98.5(b)(19). It was on this basis that a payor differential in favor of Blue Cross and HMOs was originally enacted in 1983 and has been continued to date.[3]

B. Hospital Rate Regulation In New York State From 1988-Present

In 1988, New York enacted the hospital rate-setting system, parts of which are challenged here. It is a prospective reimbursement system based, in large part, on a case payment methodology in which hospitals are paid a set amount for each patient treated, depending on the diagnostic related group ("DRG") to which the patient is assigned. There are 794 DRGs and the rate for each is the average cost of treating a patient in that DRG at a particular hospital (JA 152).[4]

Another component of the hospital rate is a payor differential. Hospitals bill patients who are covered by Medicaid, Blue Cross and HMOs at the case payment rate for the DRG to which the patient is assigned. N.Y. Pub. Health Law § 2807-c(1)(a). Hospitals bill patients covered by workers' compensation, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, "no fault" motor vehicle insurance, commercial insurance, and self-insured funds that make payments

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[3] In addition to Blue Cross and HMOs, New York's Medicaid program receives the benefit of not paying the differential since it provides care to poor New Yorkers, regardless of health condition, who otherwise would be uninsured.

[4] A hospital's DRG rate is the sum of at least six different components, including an operating cost component, a capital cost component, a bad debt and charity care allowance, a trend factor for inflation, and factors reflecting medical malpractice costs and excess medical malpractice costs (JA 152). Some hospitals' DRG rates also include a financially distressed hospital adjustment. The rates for the same DRG vary from hospital to hospital since much of the cost data used to compute a hospital's DRG rates is derived from that hospital's unique cost history and capital costs (JA 152).

directly to hospitals, 113% of the applicable DRG rate, with a 2% discount allowed for prompt payment. N.Y. Pub. Health Law § 2807-c(1)(b),(11)(e). Uninsured patients and patients covered by self-insured funds that do not make direct payments to hospitals are in a third category. They are billed "charges", *i.e.*, prices set by the hospital for the particular services rendered. Charges may not exceed approximately 131% of the DRG rate which would otherwise apply (JA 154).

In 1988, the New York State Department of Insurance reported that Blue Cross plans were losing better risk customers to commercial insurers (JA 164). The commercial insurers, through underwriting practices, insured only the healthiest customers, thereby keeping their rates down and leaving Blue Cross plans with the poorest risks (JA 165-66). After 1988, the Blue Cross plans continued to face shrinkage of their community-rated pools and underwriting losses, which in turn resulted in repeated Blue Cross requests to the Department of Insurance for substantial rate increases (JA 166).

Proposals that address this situation directly were enacted in 1992, and became effective on April 1, 1993. 1992 N.Y. Laws, ch. 501. These provisions, not challenged here, require community rating and open enrollment by all insurers who choose to compete in the individual and small group market.

In addition, in 1992, New York imposed, for a one-year period, an 11% surcharge on the hospital bills of patients covered by commercial insurance. N.Y. Pub. Health Law § 2807-c(11)(i). The 11% surcharge was enacted primarily to remedy the deterioration in the Blue Cross plans' financial position and the effect of that deterioration on New York's health care system (JA 165-66). The 11% surcharge was to be assessed upon hospital bills paid by commercial insurers until the effective date of the new law (JA 167).[5] Hospitals collected the money which was

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[5] The challenge to the 11% surcharge is not moot because respondents refused to pay it. The monies have been paid into escrow (A-94).

then paid over to the State's general fund. N.Y. Pub. Health Law § 2807-c(14-e).

C. The HMO Assessment

New York is among the states attempting to contain escalating Medicaid costs by encouraging Medicaid recipients to enroll in "managed care" programs.[6] In 1992, New York enacted a contingent assessment to be imposed upon HMOs to encourage HMOs to enter into "managed care contracts" with local social services districts and to enroll a target number of Medicaid recipients (JA 175-76). N.Y. Pub. Health Law § 2807-c(2-a). The amount of the assessment is a maximum of 9% of the total inpatient costs of non-Medicaid patients who are enrolled in HMOs. It is eliminated if an HMO becomes a Medicaid managed care provider and enrolls at least 90% of a target number of Medicaid-eligible persons. The 9% assessment is also reduced by 25%, 50% or 75%, if the HMO enrolls a like percentage of a target number of Medicaid-eligible persons (JA 175-76). It is payable on a monthly basis into a statewide HMO pool and credited to the State's general fund (JA 175).

D. The Employee Retirement Income Security Act

The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*, subjects employee benefit plans, including employee pension benefit plans and employee welfare benefit plans, to federal regulation. ERISA was enacted to guard against abuse in the "establishment, operation and administration of

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[6] Managed care is a system of delivering medical care in which a primary care provider is responsible for the management of the medical and health care needs of participants, including referral, coordination, monitoring and follow-up (JA 174). Coordination is particularly significant in Medicaid where there has been a history of uninsured persons' utilizing emergency rooms for primary care. It is intended to save money by emphasizing less costly primary care and by allowing the managed care provider to restrict the use of some expensive medical procedures.

plans." 29 U.S.C. § 1001(a). ERISA requires employee welfare benefit plans to comply with federal standards governing reporting, disclosure and fiduciary responsibilities, 29 U.S.C. §§ 1021-1030, 1101-1114, but it does not prescribe, or otherwise regulate, substantive benefit plan terms.

ERISA expressly provides that it "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan...." 29 U.S.C. § 1144(a) (A-99). The preemption provision is substantively qualified by an insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), which states that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities" (A-99).

E. Prior Proceedings

On June 2, 1992, the Travelers Insurance Company commenced this action challenging the 13% differential and the 11% surcharge contained in N.Y. Pub. Health Law § 2807-c as preempted by ERISA (JA 1, 68). On August 10, 1992, the Health Insurance Association of America ("commercial insurers") and several insurance companies and trade associations commenced a separate action challenging the 9% HMO assessment, in addition to the 13% differential and 11% surcharge, as preempted by ERISA (JA 16).[7] The actions were heard together and the parties cross-moved for summary judgment on all claims (JA 2, 3, 4).

On February 3, 1993, the district court issued a decision and order holding that the 13% differential, the 11% surcharge, and the 9% HMO assessment (the "health care assessments") were preempted by ERISA because they "lead, indirectly, to an increase in plan costs" (A-71). While recognizing that none of the state

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[7] The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York State intervened as defendants (JA 2). The New York State Health Maintenance Organization Conference and several HMOs intervened as plaintiffs (JA 4).

laws has a direct effect on the structure or administration of ERISA plans, the court nevertheless held that indirect economic impact may affect the structure and administration of plans by encouraging plans to reduce the level of benefits, a result "which ERISA was designed to avoid" (A-74). The district court acknowledged that its decision meant that states would be precluded from regulating hospital rates for patients who are covered by ERISA plans, but said that any concern about this consequence had to be directed to Congress, not the courts (A-78). The district court also held that none of the challenged provisions were within ERISA's insurance saving clause, 29 U.S.C. § 1144(b)(2)(A), which exempts from preemption laws regulating insurance (A-80). The district court enjoined enforcement of the assessments against commercial insurers and HMOs (A-90).

On October 25, 1993, the United States Court of Appeals for the Second Circuit affirmed the district court's holding that the health care assessments relate to ERISA plans because they impose a significant economic burden on commercial insurers and HMOs, and thereby have an impermissible impact on the structure and administration of ERISA plans (A-24).

The Second Circuit found that the 13% differential and the 11% surcharge were designed to increase hospital costs for patients covered by health plans other than Blue Cross and, therefore, "obviously" affected ERISA plans' health care benefits (JA 52). Likewise, the court held that the 9% assessment increased the cost of HMO coverage, thus interfering with an ERISA plan's selection of the most effective way to provide benefits (JA 52). This interference was held sufficient to constitute a connection with ERISA plans (JA 52).

The Second Circuit also held that the health care assessments related to ERISA plans because they substantially increased the cost to ERISA plans of providing a given level of health care benefits. The court expressly rejected the argument that indirect economic impact, standing alone, does not support a finding of preemption (JA 54). It also expressly declined to follow the reasoning of the Third Circuit in *United Wire, Metal & Mach.*

Health & Welfare Fund v. Morristown Memorial Hosp., 995 F.2d 1179, (3rd Cir.), *cert. denied*, 114 S.Ct. 382 (1993), holding that a similar New Jersey hospital rate statute's "indirect ultimate effect of increasing plan costs" placed it beyond ERISA preemption (JA 55).

The Second Circuit also rejected the argument that the assessments were saved from ERISA preemption because they regulated insurance. The court held that the 13% differential and the 11% surcharge did not come within the common-sense meaning of the term "regulates insurance" because they regulate hospital rates (JA 57). Applying the three insurance factors from the McCarran-Ferguson Act, 15 U.S.C.§ 1011 *et seq.*, the court held the state laws met only one; they affected the transfer or spreading of a policyholder's risk by encouraging plans to switch to Blue Cross (JA 59). The Second Circuit held that they did not regulate any practice that is integral to the insurer-insured relationship and were not limited to entities within the insurance industry and, therefore, were not saved from ERISA preemption (JA 59-60). Finally, the court held that HMOs were not, as a matter of law, in the business of insurance so that the 9% assessment was also not saved by the insurance saving clause (JA 60). The court granted New York's petition for rehearing and issued an amended opinion on January 14, 1994. It addressed an issue not decided in the original opinion, but did not alter its ERISA preemption analysis.

SUMMARY OF ARGUMENT

The health care assessments are state laws of general application which affect the cost of hospital services, but which do not, directly or indirectly, dictate or restrict ERISA plans' benefits, structure, or administration. They, therefore, do not "relate to" plans. The assessments are part of the State's hospital rate regulation system which affect employee benefit plans only to the extent that plan participants purchase inpatient hospital care in the health care marketplace. The 13% differential and the 11% surcharge are imposed on hospital bills paid by third-parties on behalf of hospital patients without regard to the payor's

relationship to ERISA plans. Hospital patients who are ERISA plan participants fall within all payor categories, and all payor categories include both ERISA plan participants and others. The 9% assessment is imposed upon HMOs, without regard to whether their customers are ERISA plan participants.

While ERISA plans are a major source of private health care coverage, that fact does not transform the health care assessments into laws directed at ERISA plans or dependent on ERISA plans' existence. Thus, these laws do not fit within decisions of the Court that have preempted state laws on that basis. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), and in *District of Columbia v. Greater Washington Board of Trade*, ___ U.S. ___, 113 S. Ct. 580 (1992), the Court preempted statutes which could not be meaningfully applied without reference to ERISA plans. Here, the health care assessments would function in exactly the same way even if ERISA plans did not provide health care coverage as a benefit. ERISA plans' predominance in the health care market also does not alter the analysis of whether a law's impact on plans is remote and tenuous. That analysis depends upon the nature of the impact on ERISA plans, not the number of ERISA plans affected.

The health care assessments may have an indirect economic effect upon ERISA plans. The Court has never addressed whether ERISA preempts a state law that may have solely an economic effect on ERISA plans' cost of providing benefits. Cases in which the Court preempted state laws involved state regulation which dictated or restricted plan conduct. However, in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), the Court upheld a state garnishment statute that imposed requirements upon plan administration, rejecting the argument that the substantial economic and administrative burdens the statute imposed upon plans required preemption. In construing the meaning of "relate to," the Court looks to the congressional purpose of ERISA preemption, to allow uniform administration of plans. The health care assessments do not raise this concern as they do not dictate or restrict plan administration. While the assessments may affect ERISA plans' cost of doing business, plans remain subject to

nationally uniform supervision. The costs of providing benefits necessarily varies from state to state, with or without the health care assessments.

Economic impact upon plans, even a substantial economic impact, by itself is not a sufficient connection to plans to "relate to" them. States regulate extensively, pursuant to their police power, in the health care field and in other areas where ERISA plans provide benefits. Police power regulation will have a financial impact on plans' cost of providing benefits. The health care assessments, like state regulation of hospital capital improvements, medical waste disposal, minimum hospital staffing requirements, and a whole host of other regulations, increase the cost of providing medical care and, therefore, the cost of health care coverage provided by plans. As the cost of medical care increases, plans may respond by reducing benefits, but there is nothing in ERISA's language, structure, or legislative history to indicate that ERISA was designed to protect participants from this possibility.

The health care assessments may influence plan content or administration because they do not affect all payors equally. State regulation does not affect every aspect of plan administration or benefits identically and, therefore, a wide range of state regulation may influence ERISA plan activity. However, this effect does not "relate to" plans because it does not dictate or restrict plan content or administration.

Even assuming the Court decides that the health care assessments "relate to" ERISA plans, the 13% differential and the 11% surcharge are saved from preemption as laws regulating insurance. The 13% differential and the 11% surcharge meet the Court's "common-sense" test because they are specifically directed at the insurance industry and seek to ensure its viable functioning by facilitating the transfer and spreading of risk. The 11% surcharge was imposed only upon commercial insurers and was designed to remedy the problem of poorly distributed risk by stemming the continued shrinkage of the Blue Cross plans' community-rated risk pools. The 13% differential is, in effect, a

discount from the basic rate, DRG plus 13%, for those payors which use the risk-spreading practices of open enrollment and community rating. It is imposed to account for the greater costs incurred by Blue Cross plans and HMOs as a result of these risk-spreading practices. Although HMOs are hybrid entities, the 13% differential affects them only in their insurer function which HMOs perform when they practice open enrollment and community rating.

The 13% differential and the 11% surcharge also meet all of the three factors enunciated by the Court in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), to determine what constitutes the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.* The 13% differential and the 11% surcharge meet the first *Pireno* factor as they spread risk by compensating insurers with the broadest risk pools for the higher costs of insuring the poorest risks who, but for these practices, might not be insured. They meet the second *Pireno* factor by fostering, through open-enrollment and community rating, the formation of policy relationships without regard to age, sex, health or occupational status. Finally, they are limited to entities in the insurance industry since they are imposed only by virtue of a payor's status in the insurance marketplace.

Furthermore, the Court has interpreted the *Pireno* factors more broadly when evaluating state laws for preemption purposes under the McCarran-Ferguson Act than when evaluating them for anti-trust purposes. *United States Department of Treasury v. Fabe*, ___ U.S. ___, 113 S. Ct. 2202 (1993). ERISA's insurance saving clause serves the same policy as the preemption-limiting clause of the McCarran-Ferguson Act and, therefore, the broader reading of the business of insurance should apply in this case.

ARGUMENT

POINT I

THE HEALTH CARE ASSESSMENTS DO NOT RELATE TO ERISA PLANS SINCE THEIR ONLY CONNECTION TO PLANS MAY BE TO INCREASE INDIRECTLY SOME ERISA PLANS' COST OF PROVIDING HEALTH COVERAGE.

ERISA preempts state laws that "relate to" ERISA plans. The words "relate to" are broad, but not unlimited. They are to be given their common-sense meaning of having "a connection with or reference to" a plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 (1983). The health care assessments have none of the connections to plans which the Court in prior decisions has held to "relate to" plans. The assessments, like many other state regulations, may affect a plan's cost of doing business. However, this effect is not one which ERISA preemption was designed to prevent. While differences in the cost of benefits may influence a plan's decisions concerning its scope and content, such an effect does not restrict or dictate benefit choices or plan administration. It does not, therefore, result in ERISA preemption.

A. The Health Care Assessments Are Laws of General Applicability Which Neither Single Out ERISA Plans for Special Treatment Nor Are Predicated upon the Existence of Plans.

New York's health care assessments are state laws of general application with only a "tenuous, remote or peripheral connection" to employee benefit plans and, as such, do not relate to plans. *District of Columbia v. Greater Washington Board of Trade*, ___ U.S. ___, 113 S. Ct. 580, 583, n. 1 (1992). The health care assessments do not single out ERISA plans or subject them to

special treatment.[8] Hospitals are required to bill all patients, including participants in ERISA plans, according to the statutory methodology. ERISA plan participants fall within all three payor categories depending on the type of health care coverage provided by the plan. Those who have HMO or Blue Cross coverage are charged the DRG rate. N.Y. Pub. Health Law § 2807-c(1)(a). Those who have commercial insurance or whose plans self-insure and make payments directly to the hospital are charged 113% of the DRG rate. N.Y. Pub. Health Law § 2807-c(1)(b). Other ERISA plan participants are billed charges which cannot exceed approximately 131% of the DRG rate. N.Y. Pub. Health Law § 2807-c(1)(c). Many ERISA plans give participants a choice of health care coverage, for example, HMOs or commercial insurance. These plans have participants in more than one payor category. Moreover, all three payor rate categories apply to both ERISA and non-ERISA covered patients.[9]

The health care assessments affect employee benefit plans only to the extent that plan participants are consumers in the health care market. The 13% differential and 11% surcharge, imposed upon hospitals bills covered by certain third party payors, apply irrespective of the relationship between those payors and ERISA plan participants. The 9% assessment is imposed directly upon HMOs, again irrespective of any relationship between an HMO and an ERISA plan participant. The commercial insurers and HMOs have argued that laws directed at health care are not generally applicable and their impact upon ERISA plans is not "remote and tenuous" because most Americans who have private health care coverage receive it through employee benefit plans. The Second Circuit agreed, stating in the first line of its opinion: "Eighty-eight percent of all non-elderly Americans have private

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[8] We use the short-hand term "ERISA plans" instead of employee benefit plans, while recognizing that some employee benefit plans are exempt from ERISA coverage and, thus, are not implicated in this case, *e.g.*, governmental plans. 29 U.S.C. § 1003(b)(1).

[9] For example, Blue Cross, HMOs, commercial insurers, and self-insured funds cover ERISA and non-ERISA plan participants and others.

health care insurance through their employee welfare benefit plans" (JA 35).[10] The court's analysis, grounded on the fact that ERISA plans are a major source of private hospital care coverage, incorrectly transforms the health care assessments from laws of general applicability into ones directed at ERISA plans.[11] A law

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[10] The Second Circuit reiterated this view in its subsequent opinion in *NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823 (1994). In *NYSA-ILA*, the Second Circuit held that a 0.6% assessment on hospital gross receipts, including receipts for patient care services, was preempted insofar as it was applied to a medical facility owned by an ERISA plan. Rejecting New York's argument that the assessment was a state tax law of general applicability which affects ERISA plans only incidentally, the court held:

> The HFA does not apply broadly to every sector of society in New York; nor does it apply to the Fund simply because it engaged in certain kinds of activities which any other member of society might engage in, such as purchasing gasoline or paying one's employees. Rather, the HFA targets only the health care industry. Because this industry is, by definition, the realm where ERISA welfare plans must operate, the HFA was bound to affect them.

Id. at 827.

[11] The primary purpose of these assessments is to control health care costs and to reduce the number of uninsured New Yorkers by assuring widely available and affordable coverage, especially in the small group market (JA 163). A recent government report found that 75% of the Americans who lack health insurance are workers (and their dependents) and over half of these workers are employed in firms of 25 or fewer, *i.e.*, employers in the small group market. In addition, the report noted that 30% of small businesses are considering dropping health care benefits because of the cost. General Accounting Office, ACCESS TO HEALTH INSURANCE: STATE EFFORTS TO ASSIST SMALL BUSINESSES, GAO/HRD-92-90 (May 1992). Yet, these facts do not transform the health care assessments into laws designed to interfere with an ERISA plan's decisions whether or not to provide health care benefits.

of "general applicability" is one applicable to a broader class than that at issue in a particular case.[12] As applied to ERISA cases, a law of general applicability is one not restricted to employee benefit plans and which does not accord them any different treatment. The fact that employee benefit plans are a large segment of a broader class covered by a law does not make the law any less one of general applicability. Nor does it transform state laws which regulate generally in the health care field into laws which single out ERISA plans.

Statistics do not alter the analysis of whether a state law's impact on plans is "remote and tenuous." Whether a law's relationship to an ERISA plan is remote and tenuous must depend on the nature of the impact on the plan, not on how many plans are affected. ERISA plans are the primary source of private health care coverage. Thus, unless plans are specifically excluded from state health care regulation, much of the impact of regulation in the health care field will obviously fall on them.[13] In this case, the argument that the health care assessments "relate to" plans because they are paid primarily by plans tells only part of the story since the benefit of avoiding the 13% and 11% provisions also

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[12] *Gade v. National Solid Wastes Management Ass'n.*, ___ U.S. ___, 112 S. Ct. 2374 (1992), involved preemption under the Occupational Safety and Health Act, 29 U.S.C. § 651 *et seq.* The Court noted that, in that context, non-occupational safety laws which affected workers, such as traffic safety laws or fire safety laws were laws of general applicability. 112 U.S. at 2387-8. In *New York State v. United States*, ___ U.S. ___, 112 S. Ct. 2408 (1992), a Tenth Amendment case, the Court indicated that laws that subjected states to the same standards as private parties were "generally applicable laws." 112 S.Ct. at 2420.

[13] *See, e.g., New England Health Care Employees Union Dist. 1199 v. Mt. Sinai Hospital*, 846 F.Supp. 190, 196 (D.Conn. 1994) in which the court, relying on the Second Circuit's decision in *Travelers*, held that a generally applicable assessment on hospital revenue, which was passed through to ERISA plans that paid their participants' bills, was preempted because 70% of the money raised by the assessment came from ERISA plans.

falls primarily on ERISA plans—those that use Blue Cross or HMOs. This result flows from plans' predominance in the health care market, not from the state laws' effect on those ERISA plans. Under the quantitative analysis of impact used by the Second Circuit, if a large percentage of working Americans obtain child care through ERISA plans, state regulation of day care centers would also be preempted, because it would affect the cost of a benefit provided by a large number of ERISA plans.

The health care assessments are not predicated upon the existence of ERISA plans, as were the state laws at issue in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, or *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580. In *Ingersoll-Rand*, 498 U.S. at 140, the Court held that a state law cause of action for wrongful termination, when the employer's motivation was to avoid paying pension benefits, "related to" plans because, without a pension plan, there would be no cause of action. In *Greater Washington Board of Trade*, 113 S. Ct. at 583, the Court held that a law, which imposed requirements only on employers who provided health care benefits and which tied the requirements to the level of benefits provided by the employer's benefit plan, "related to" plans because it referred to and was dependent upon the existence of plans. As the Third Circuit recognized in *United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d at 1192, n. 4, in those cases the statutes could not be meaningfully applied but for the existence of ERISA plans. In contrast, hospital rate-setting statutes, and the particular components challenged in this case, can be applied and would function even if ERISA plans did not provide health care coverage as a benefit.[14] The same is true of the HMO assessment, which is predicated upon the existence of HMOs, not upon the identity of their non-Medicaid customers.

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[14] If non-indigent patients do not obtain hospital care coverage as an employment-related benefit, they must either obtain their own health insurance coverage, at which point they will fall under N.Y. Pub. Health Law § 2807-c(1)(a) or (b) or (c), depending on which coverage they have, or they will be uninsured and treated as "charge payors" under N.Y. Pub. Health Law § 2807-c(1)(c).

There is no evidence that Congress, in enacting ERISA, envisioned that ERISA plans would displace the states' ability to regulate in areas of traditional state concern simply by providing benefits in the area. The benefits that ERISA plans provide, health care, child care, legal services, disability and life insurance, are areas of traditional state concern. There is little or no federal substantive regulation in these areas. Congress did not intend "fundamentally to alter traditional preemption analysis," when it designed ERISA, *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, ____ U.S. ___, 114 S. Ct. 517, 526 (1993). Therefore, it must be "presume[d] that Congress did not intend to preempt areas of traditional state regulation." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985), quoting *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977).

There is nothing in ERISA's language, structure or legislative history which demonstrates a congressional intent to preempt generally applicable state health care regulation merely because ERISA plans provide a substantial portion of health care coverage. ERISA does not require employers to provide health care coverage or any other employee benefit. ERISA was intended to "preempt the field for Federal regulation, thus, eliminating the threat of conflicting and inconsistent State and local regulation of employee benefit plans." 120 Cong. Rec. 29933 (1974) (statement of Senator Williams). That is a different and more limited purpose than creating a regulatory vacuum in an area of traditional state concern simply because employee benefit plans provide benefits in that area.

B. The Indirect Economic Impact of State Regulation upon Plans is Not Sufficient to Trigger Preemption Because it Does Not Dictate or Restrict Plan Benefits, Structure or Administration.

The impact of the health care assessments on ERISA plans is an indirect economic one. The effect is indirect because the assessments are not imposed upon ERISA plans, but rather upon services which plans may purchase on behalf of their participants.

The 13% differential and the 11% surcharge are components of a state law which requires hospitals to bill patients for services at certain rates. Although the calculation of a patient's hospital bill takes into account the identity of the payor involved, the law does not require any ERISA plan or third party payor to pay any benefit, any level of benefit, or any particular amount of a patient's hospital bill. Similarly, the 9% assessment requires HMOs to pay a variable assessment, but does not hold any ERISA plan responsible for the payment.

The impact of the assessments upon plans is, thus, solely economic, inasmuch as the assessments affect only the price of services which ERISA plans may purchase. Depending on whether an ERISA plan is insured or self-insured, the 13% differential and the 11% surcharge may affect either the price of insurance or the price of hospital care paid on behalf of a participant. The 9% assessment may affect the price of HMO services purchased by a plan.

1. Prior Decisions of the Court Suggest that a State Law's Indirect Economic Impact Alone Does Not Trigger ERISA Preemption.

The Court has never held that ERISA preempts a state law with solely an indirect economic impact on plans. State laws which refer to, are predicated upon, or which function only through the existence of, ERISA plans are preempted. Thus, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, a state law cause of action that would not exist but for the existence of a pension plan was held to "relate to" plans.[15]

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[15] In *District of Columbia v. Greater Washington Board of Trade*, 113 S. Ct. 580, a state law was preempted for similar reasons. The state law referred to and imposed requirements by reference to employee benefit plans. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, that portion of a state law that made specific reference to "ERISA plans" and singled them out for different treatment was preempted. As

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All of the Court's prior ERISA preemption cases involved state laws which affected ERISA plans by regulating, directly or indirectly, substantive plan conduct or plan administration. Thus, state laws have been found to "relate to" plans when they conflict with substantive provisions of ERISA, as in *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981). In that case, a New Jersey statute that prohibited plans from decreasing pension benefits by the amount of workers' compensation benefits awarded after retirement was held to "relate to" plans. Although the law affected plans indirectly through a workers' compensation statute, it prohibited plans from using a method to calculate benefits that was permitted by ERISA. Laws have been found to "relate to" plans when they directly or indirectly imposed substantive requirements upon plan conduct. In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, a Massachusetts insurance law that mandated minimum benefits for plans that purchased insurance "related to" plans. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 97, that portion of New York's Human Rights Law which, by prohibiting sex discrimination in employment, would have required plans to provide pregnancy disability benefits was held to "relate to" plans. State laws that require plans to be structured in a particular manner "relate to" plans. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), a Pennsylvania anti-subrogation statute, which prevented plans from being structured so as to require reimbursement from a third party in the event of recovery, "related to" plans. Finally, laws that provide an alternative cause of action for collecting benefits, such as the state cause of action for improper processing of a claim, "relate to" plans. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41.

However, prior decisions of the Court have suggested that economic impact is insufficient to result in ERISA preemption. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, the Court upheld a Georgia garnishment statute that directly imposed substantive requirements upon plans. As garnishees, plan

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[15](...continued)
the Second Circuit recognized, the health care assessments do not refer to ERISA plans and, therefore, this line of cases is inapplicable.

trustees had to become parties to state lawsuits and make decisions with respect to the validity and priority of garnishments. They were even subject to state substantive law concerning spendthrift trusts. Yet, the Court rejected the argument that these substantial economic and administrative burdens alone required preemption. Moreover, in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 741, the Court, in dicta, noted that laws which regulate only an insurer or how it sells insurance do not "relate to" plans. Yet, those laws increase the cost of insurance over what it would be in the absence of regulation and may increase the cost of ERISA plans that purchase insurance.[16]

2. State Laws that Affect the Prices that Plans Pay for Goods and Services Do Not Interfere with Plan Uniformity.

The Court has always been careful to construe the meaning of "relate to" in the context of the congressional purpose of ERISA preemption. Indirect economic impact alone does not implicate the congressional concerns of ERISA preemption, at least not when the impact is the result of higher benefit prices. The purpose of ERISA's preemption provision is to eliminate conflicting and inconsistent regulation of benefit plans. 120 Cong. Rec. 29197 (1974). Congress believed that uniform regulation would "help administrators, fiduciaries, and participants to predict the legality

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[16] In New York, commercial insurers, HMOs and Blue Cross are subject to examinations by the state, N.Y. Ins. Law § 309 (commercial insurers)' N.Y. Pub. Health Law § 4409 (HMOs), N.Y. Ins. Law § 4313(a) (Blue Cross); are required to prepare detailed annual financial reports, N.Y. Ins. Law § 307(a) (commercial insurers), N.Y. Pub. Health Law § 4408 (HMOs), N.Y. Ins. Law § 4313 (Blue Cross); are required to be audited by outside certified public accounting firms, N.Y. Ins. Law § 307(a) (commercial insurers), N.Y. Pub. Health Law § 4408 (HMOs), N.Y. Ins. Law § 4313 (Blue Cross); and have their loss reserves certified by a qualified actuary, N.Y. Ins. Law § 1303 (commercial insurers), N.Y. Pub. Health Law § 4408 (HMOs), N.Y. Ins. Law § 4310 (Blue Cross). Reserves, both minimum amounts and minimum length of time held, are also regulated. *Id.* All of these requirements increase operating costs.

of proposed action without the necessity of reference to varying laws." House Rep. No. 533, 93rd Cong., 1st Sess. 12 (1973). Thus, plans would only have to look to federal law to determine if their conduct is legal. Uniformity would be achieved by conforming conduct to one set of federal requirements. If there were no federal requirements (as is often the case with welfare benefit plans), plans would be free to develop their own requirements. In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Court described the problems created for plans by conflicting or inconsistent state and local regulations as follows:

> An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations. . . . The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States.

482 U.S. at 9.

New York's health care assessments do not raise these concerns. They do not require plans to provide additional or different benefits, to calculate eligibility for benefits, or to process claims any differently. They do not interfere with record-keeping requirements or vary fiduciary standards. Increases in hospital bills or insurance premiums do not interfere with, or modify, plan terms. Regardless of the amount of the hospital bill, the plan's responsibility is governed by its plan terms, whatever they are.

The fact that the health care assessments may make hospital bills or insurance premiums more expensive than they would otherwise be or than they may be in other states does not cause increased administrative burdens to plans. Plan administrators do not have to do anything different in New York because a participant's hospital bill is higher. It takes no more

administrative effort to process a claim for $113 than to process one for $100.

State laws that affect only the price of goods or services which plans purchase do not interfere with interstate uniformity. Preemption of state laws that impose, directly or indirectly, substantive obligations on plans, results in uniform obligations. Preemption of state laws that affect only the cost of benefits, however, does not result in uniform costs. Even in the absence of state hospital rate regulation, plans would not pay the same amount for hospital care in each state. Plans can be, and indeed are, subject to nationally uniform supervision although their costs of doing business vary from state to state, or even from city to city.

3. A State Law Does Not Relate to Plans Because of the Degree of Its Economic Impact on Plans.

The Second Circuit, relying principally upon the Court's decision in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, held that the health care assessments "relate to" plans because the plans might respond to the "substantial economic impact" of the assessments on the cost of benefits by reducing benefits (JA 52-53).

However, neither *Ingersoll-Rand* nor any other decision of the Court has interpreted the phrase "relate to" in such a broad fashion. In *Ingersoll-Rand*, the Court recognized that ERISA preemption is not limited to state laws that "purport to regulate" ERISA plans, that are specifically designed to affect ERISA plans, or that directly affect ERISA plans. However, the state law at issue in that case, a cause of action for wrongful termination when the employer's motivation was to avoid paying pension benefits, while affecting plans only indirectly, made "specific reference to," and "was premised on the existence of a pension plan." *Ingersoll-Rand*, 498 U.S. at 140. Thus, the Court was careful to note that it was not dealing with a law of general applicability that makes "no reference to and, indeed, functions irrespective of the existence of ERISA plans." 498 U.S. at 139.

In addition, the Second Circuit's use of "substantial" provides no objective limitation to the economic impact standard. It is not the degree of the financial impact which determines if a state law is preempted. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, the Court recognized "[l]awsuits against ERISA plans for run-of-the-mill state law causes of action such as unpaid rent, failure to pay creditors, or even torts committed by ERISA plans are relatively commonplace . . . [and] although obviously affecting and involving ERISA plans are not preempted by ERISA." 486 U.S. at 833. Yet these suits, too, can have substantial negative economic effects upon plans. There are areas in which states regulate, without regard to ERISA, which can result in significant negative economic effects on plans. States regulate electricity, water, sewer, and heating oil rates, often to the significant financial disadvantage of certain groups, which could include ERISA plans. For example, New York requires telephone companies to charge higher commercial rates which subsidize lower residential rates. ERISA plans, which pay commercial rates in New York, pay higher rates than they would if the state did not require this differential.

New York regulates extensively in the health care area and any number of these regulations affect the cost of providing health care coverage. New York regulates hospitals' expansion and other capital improvements and includes a capital cost component in the DRG rate. N.Y. Pub. Health Law § 2802, 2807-c(8). The State regulates the training of doctors and the working conditions of residents and allows training hospitals to include these costs in their rates. N.Y. Pub. Health Law § 2807-c(7)(c), N.Y. Comp. Codes R. & Regs. tit. 10 § 404.4(b). The State imposes staffing requirements and regulates the working conditions of medical support personnel. N.Y. Comp. Codes R. & Regs. tit. 10 part 405. It imposes sanitary standards on hospitals. N.Y. Pub. Health Law §§ 1389-aa--1389-hh. All of these regulations can significantly increase the rates for hospital care and, therefore, the price paid by ERISA plans directly, or indirectly through an insurer. As the Third Circuit recognized in *United Wire Metal & Machine Health & Welfare Fund v. Morristown Memorial Hospital*, 995 F.2d, at 1196 states are beginning to regulate the

disposal of medical wastes. Such regulation can significantly increase a hospital's, medical laboratory's or a physician's cost of doing business and, correspondingly, its billings to ERISA plan participants. Some states cap malpractice awards against physicians and an increase in that cap would increase the cost of physicians' malpractice insurance and, thus, the physicians' billings to ERISA plan participants.

State regulations may also affect the cost of other benefits ERISA plans provide. New York regulates the cost of tuition at state universities. N.Y. Educ. Law § 201 *et seq.* It sets minimum standards for day care centers. N.Y. Soc. Serv. Law §390. Increases in the cost of tuition at state universities would force plans which provide tuition assistance to absorb increased costs or reduce benefits. Enactment of more stringent day care regulations would likely increase the costs of operating day care centers, forcing plans who provide child care benefits to absorb the increased cost or reduce benefits. All of these increases in areas where ERISA plans provide benefits may be substantial. Yet there is nothing in the structure, purpose, or the legislative history of ERISA which indicates that Congress intended ERISA plans to be exempt from increases in the price of benefits provided.

Nor is there any evidence that, in enacting ERISA, Congress was concerned with protecting plan participants from increased benefit prices. The statutory structure of ERISA does not protect a plan participant's right to specified welfare benefits. ERISA does not require the provision of benefits. It does not govern the substantive terms of employee welfare benefit plans. ERISA contains no provisions which guarantee minimum welfare benefits, unlike pension benefits. There are no vesting requirements and no minimum funding requirements for welfare plans. The primary congressional purpose in regulating welfare plans was to prevent trustee mismanagement of funds—a purpose which is not implicated in any way by state regulations that increase benefit costs.

Congress allowed employers subject to ERISA the freedom to change or eliminate medical benefits (as opposed to vested pension

benefits) because of the variables that make predicting future medical costs difficult, if not impossible. Plans are often amended to contain costs and these amendments have been uniformly upheld when challenged by plan participants. *McGann v. H & H Music*, 946 F.2d 401 (5th Cir. 1991) *cert. denied*, ___ U.S. ___, 113 S. Ct. 482 (1992); *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2nd Cir. 1988); *Musto v. American General Corp.*, 861 F.2d 897 (6th Cir. 1988), *cert. denied*, 490 U.S. 1020 (1989).

Even if substantial economic impact provided a basis for meaningful analysis, the Second Circuit did not apply it in a useful manner. Looking at the naked percentages, 9, 11, 13, the court of appeals held the economic impact was substantial. However, those numbers alone do not reflect the impact on the plans or its costs.[17] For example, the 9% assessment may be reduced or eliminated by HMOs that enroll their target number of Medicaid recipients. The record shows that HMOs that were assessed the full 9% raised their rates 3.5% (Rachlin Affidavit and Exhibits). Thus, a plan in which 20% of the participants are enrolled in such HMOs would experience only a 0.7% increase in health care costs. The actual impact of the 13% and 11% assessments also varies depending upon whether a plan is insured and the percentage of plan expenditures which are spent on inpatient hospital care. Moreover, the 13% and 11% are components of a comprehensive rate-setting scheme that was designed to control increases in hospital costs. Private payors, such as ERISA plans, have benefitted enormously from this cost control scheme. Even

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[17] After the *Travelers* decision, courts have struggled with meaningful application of this test. In *Boyle v. Anderson*, 849 F. Supp. 1307, 1315 (D. Minn. 1994) the court distinguished *Travelers*, holding that Minnesota's 2% provider tax was not substantial. In *New England Health Care Employees Dist. 1199 v. Mt. Sinai Hospital*, 846 F.Supp. at 196, two 6% assessments on hospital income were deemed substantial. In *NYSA-ILA Medical & Clinical Services Fund v. Axelrod*, 27 F.3d 823, the Second Circuit preempted a 0.6% generally applicable hospital assessment which the district court had found to be *de minimis* on the basis that, because an ERISA plan owned the hospital, it was a direct tax on benefits.

with the differentials, private payors pay a lower "surcharge" over cost in New York than in any other state.[18]

C. State Laws Do Not Relate to Plans Simply Because They Influence Plan Choice.

New York's health care assessments do not "relate to" plans because they do not, directly or indirectly, impose obligations upon plan conduct. The assessments also do not dictate or restrict an ERISA plan's choice of benefits, its structure, or its administration. Collectively, they affect only the price of obtaining health care coverage from HMOs, Blue Cross, and commercial insurers and the price of hospital bills paid by self-insured funds. Since the assessments affect these payors differently, costs are not affected uniformly. Plans that take these costs into consideration may be influenced in their choices of the content or structure of their benefit plans. In the Second Circuit's view, the assessments "relate to" plans because they are not equally applicable to all forms of coverage. This was believed to result in interference with "the choices that ERISA plans make for health care coverage" (JA 52).[19] The fact that the health care assessments may affect the costs of the various forms of health care coverage unequally is irrelevant. All kinds of state regulations have an economic impact upon plans which may influence plan content or administration. There is a legally significant distinction between influencing plan choice and mandating plan conduct. State laws that do not mandate plan conduct do not "relate to" plans because they may influence plan

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[18] The federal Prospective Payment Assessment Commission ("ProPAC") reported in the 1993 Report to Congress, *Medicare and the American Health Care System*, that private payors in New York in 1991 paid a lower "surcharge" over costs (23% below the average) than did private payors in any state. ProPAC's June 1994 report showed that New York's private payors in 1992 were still paying the lowest surcharge--25% below the national average.

[19] There is no evidence in the record that any plan changed health care coverage as a result of the health care assessments.

decisions concerning content and administration of plans.[20] Just as an indirect economic impact is not enough to "relate to" plans, neither is the unequal economic impact of the health care assessments enough to "relate to" plans.

The health care assessments are no different than any other state regulation which, in myriad ways, may affect the costs of goods and services which a plan purchases and which, in turn, influence a plan's decisions concerning its content and administration. New York regulates the internal operation of commercial insurers, Blue Cross, and HMOs. These regulations are not identical and affect these insurers' comparative rates which, in turn, may influence plan choice.[21] New York's

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[20] In *District of Columbia v. Greater Washington Board of Trade*, 113 S.Ct. 580, the Court, in discussing *Shaw v. Delta Air Lines, Inc.* 463 U.S. 85, stated that "the fact that employers could comply with New York law by administering the required disability benefits through a multibenefit ERISA plan did not mean that the law related to such ERISA plans for pre-emption purposes." 113 S.Ct. at 584. However, New York's disability law could well influence decisions regarding the content and scope of ERISA plans. Plan sponsors who wish to avoid the administrative burden of having multiple plans may be influenced to include New York's minimum disability benefits as part of their multi-benefit plan. Multi-state plan administrators have an incentive to adopt the disability benefits required by the state with the most stringent requirements, so the plans can have nationwide uniformity in benefits. Plans may absorb the costs of these additional benefits or they may avoid these increased costs by reducing other benefits.

[21] For example, only HMOs may enter into provider capitation agreements, N.Y. Comp. Codes R. & Reg. tit. 10 § 98.5. This allows only HMOs to spread risk to medical providers and enhances their competitiveness with Blue Cross and commercial insurers. New York imposes different requirements upon Blue Cross, HMOs and commercial insurers regarding permissible investments. Blue Cross and HMOs are allowed only narrow categories of permissible investments and are subject to strict quantitative and qualitative standards. N.Y. Ins. Law § 1404. Commercial insurers are permitted much broader categories of

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hospital rate-setting statute allows only HMOs to negotiate discounts from the DRG rate. N.Y. Pub. Health Law § 2807-c(2)(b)(i). HMOs that take advantage of this option have lower hospital costs than any other payor. To the extent this advantage is reflected in their rates, it can influence plan choice.

Moreover, the interference argument cannot be logically limited to insulate only a plan's choice of a health care provider. In New York, for example, inpatient care is regulated much more closely than outpatient care. If this stricter regulation results in a significant increase in the cost of inpatient care, a plan might decide to reduce inpatient benefits and increase outpatient benefits. If New York significantly raises the tuition at its state universities, a plan might choose to reduce tuition assistance and increase day care benefits. A plan's choice of the benefits it offers, or the level of benefits it provides, is certainly as integral to its structure as is its choice of a third party provider of the benefits. If a plan's determination of its menu of benefits can legitimately be influenced indirectly by state regulation that increases the cost of the benefits offered, then so too can the plan's choice of who will distribute the benefits.

POINT II

THE 13% DIFFERENTIAL AND 11% SURCHARGE ARE LAWS REGULATING INSURANCE AND, THEREFORE, ARE SAVED FROM PREEMPTION.

Assuming, *arguendo*, that the Court decides that the 13% and 11% provisions "relate to" ERISA plans, they are not preempted

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[21](...continued)
investments and are subject only to a prudent person rule. N.Y. Ins. Law § 1405. The commercial insurers who are allowed greater discretion in investing have a greater opportunity for higher return and, therefore, more latitude in setting rates.

because they come within ERISA's insurance saving clause.[22] The saving clause states broadly that nothing in ERISA "shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).[23] The insurance saving clause must be broadly construed with due regard for the states' traditional powers in the field of insurance. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S., at 741. The 11% differential and the 13% surcharge, although part of the hospital rate-setting methodology, regulate insurance since they are imposed in connection with payor risk-spreading practices. In addition, they seek to ensure the viable functioning of the insurance industry by facilitating the transfer and spreading of risk.

To determine whether a law regulates insurance within the meaning of the saving clause, a court must first take a "common-sense view" of the phrase "regulates insurance." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 50; *Metropolitan Life v. Massachusetts*, 471 U.S. at 740. To be considered a law which regulates insurance, "a law must not just have an impact on the

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[22] New York did not argue that the 13% differential fell within the insurance saving clause in the Second Circuit, but believes that the Court's decision in *United States Department of Treasury v. Fabe*, 113 S.Ct. 2202, decided after argument of this case in the Second Circuit, requires consideration of that argument as to both the 13% differential and the 11% surcharge. Although New York believes the Second Circuit was wrong in holding that HMOs are not insurers "as a matter of law," it does not argue the 9% assessment is saved from preemption because, unlike the 13% differential, the 9% regulates HMOs as providers of managed medical care, not as insurers.

[23] A proviso to the clause states that no ERISA plan "shall be deemed an insurance company. . . for purposes of any law of any state purporting to regulate insurance companies [or] insurance contract. . . ." 29 U.S.C. § 1144(b)(2)(B). This clause is known as the "deemer clause." The deemer clause is not implicated in this case because the district court enjoined enforcement of the laws against only HMOs and commercial insurers, and no self-insured fund filed a cross-appeal (A-90).

insurance industry, but must be specifically directed towards that industry." *Pilot Life*, 481 U.S. at 50.

In addition to the common-sense test, a court must look to what constitutes the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.* *Pilot Life*, 481 U.S. at 48. Laws "aimed at protecting or regulating this relationship [between insurer and insured], directly or indirectly, are laws regulating the 'business of insurance.'" *United States Department of Treasury v. Fabe*, 113 S. Ct. at 2208, quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). Three factors are looked at to determine what constitutes the "business of insurance:"

> [F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Union Labor Life Ins. Co. v. Pireno, 458 U.S. at 129. None of the three criteria, commonly known as the *Pireno* factors, is determinative of whether a law regulates insurance. *Id.*

Here, the 13% differential and 11% surcharge regulate insurance under both the "common-sense" test and the *Pireno* factors. Both the 13% and 11% are specifically directed at the insurance industry and seek to ensure the viable functioning of that industry by facilitating the transfer and spreading of risk by benefitting insurers which practice open enrollment and community rating. Although components of the hospital rate-setting methodology, both the 13% and 11% payor differentials are connected to a payor's status in the insurance marketplace and are imposed in connection with payors' risk-spreading practices. They, therefore, address matters typically considered to be the business of insurance, even though they do it indirectly through a hospital rate-setting statute.

Insurance has been defined as "an arrangement for transferring and distributing risk." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979) (citing R. Keeton, Insurance Law § 1.2(a) (1971)). The Court, discussing the legislative history of the McCarran-Ferguson Act, which preserves the power of the states to regulate the business of insurance, noted the right of states to control risks and rates in the insurance industry to ensure the viable functioning of the industry. *Id.* at 221-223.

The 11% surcharge was imposed only upon commercial insurers and was meant to remedy the problem of uneven and poorly distributed risk by preventing the continuing shrinkage of the Blue Cross community-rated pools. It, therefore, was specifically directed at the insurance industry. The 13% differential is imposed to account for the greater costs incurred by Blue Cross and HMOs as a result of their risk-spreading practices of open enrollment and community rating, which furthers New York's goals of making insurance coverage more widely available and reducing the number of uninsured people. Moreover, because it was meant to lower the hospital costs and, therefore, the rates of Blue Cross and HMOs, the 13% differential is directed at matters typically within insurance regulation.

The fact that HMOs receive the benefit of not paying the differential does not alter this conclusion. In holding that the 9% assessment does not fall within the insurance saving clause, the Second Circuit said that HMOs do not "as a matter of law" engage in the business of insurance because they are not required by New York law to be licensed as insurers (JA 60). However, as New York law makes clear, HMOs are hybrid entities; they perform both a health care provider function and an insurance function. They are governed by Article 44 of the Public Health Law in regard to their health care provider function and they are governed by the Insurance Law in regard to their insurance function.[24]

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[24] HMOs are subject to the general regulating authority of the Superintendent of Insurance, N.Y. Ins. Law § 1109(e), including: prior (continued...)

When HMOs offer health care to subscribers for a set fee and assume the risk that the actual cost of the services will be greater than the fee, they are engaged in the business of insurance. *See Matter of Estate of Medcare HMO*, 998 F.2d 436, 444-45 (7th Cir. 1993); *Ocean State Physicians' Health Plan, Inc. v. Blue Cross & Blue Shield*, 883 F.2d 1101, 1108, n.7 (1st Cir. 1989) *cert. denied*, 494 U.S. 1027 (1990). Likewise, when HMOs open-enroll their subscribers and set their premium using community rating, they are engaging in an insurance function. When a state law, such as the 13% differential, is directed at the insurance component of an HMO, it is directed at the business of insurance.

The McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, has two separate provisions which concern "the business of insurance." 15 U.S.C. § 1012(b). The first clause of that sub-section reserves to the states the power to regulate insurance and provides that federal law shall not "supersede any law enacted by any State for the purpose of regulating the business of insurance." *Id.* The second clause exempts the "business of insurance" from federal antitrust laws. *Id.*

Recently, the Court adopted a more expansive interpretation of the *Pireno* factors when evaluating state laws for preemption purposes under the first clause of § 1012(b) than when evaluating

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[24](...continued)
approval of premium rates and the public hearing requirements for changes in their premium rates, N.Y. Pub. Health Law § 4403(1) and N.Y. Ins. Law § 4308; examinations of their financial affairs by the Superintendent of Insurance, N.Y. Pub. Health Law § 4409(2); review of their subscribers' contracts by the Superintendent of Insurance, N.Y. Pub. Health Law §§ 4403(1)(h) and 4406(1); community rating and open enrollment, N.Y. Pub. Health Law § 4406(1) and N.Y. Ins. Law § 4317; assessments paid by insurers and HMOs to pay the expenses of the Insurance Department, N.Y. Ins. Law § § 1109 and 332; limitations on borrowing and pledging assets, N.Y. Ins. Law § 1307; and liquidation, rehabilitation and dissolution requirements, N.Y. Ins. Law § 1109; restrictions on investment, N.Y. Ins. Law § 1109(d).

laws for antitrust purposes under the second clause. *Fabe*, 113 S.Ct. at 2209-2210. The Court noted the different language and the different purpose of the two clauses. The first clause was intended to give states "broad regulatory authority" over the business of insurance; the second clause was intended "to carve out only a narrow exemption . . . from the federal antitrust laws." *Id.* at 2210.

The Court stated that the "broad" category of laws enacted for the purpose of regulating the business of insurance "consists of laws that possess the 'end, intention, or aim' of adjusting, managing or controlling the business of insurance." *Id.* This category of laws "necessarily encompasses more than just the business of insurance." *Id.* The Court also concluded that laws which protected the relationship between the insurer and insured indirectly were laws regulating the business of insurance. *Id.* at 2208.

The ERISA insurance saving clause serves the same policy as the first clause of § 1012(b), permitting the state regulation of insurance, since it was "designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States." *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. at 744, n. 21. The ERISA insurance saving clause concerns preemption of state laws regulating insurance and not protection of insurance companies from antitrust laws. The language of ERISA's saving clause is also broader than the narrow language of the antitrust exemption in the McCarran-Ferguson Act. It is not limited to "the business of insurance," but exempts all state laws "regulating insurance." 29 U.S.C. § 1144(b)(2)(A). Thus, the broader reading afforded to cases arising under the first clause of § 1012(b) applies to this case.

The 13% differential and the 11% surcharge meet all three of the *Pireno* factors that have been applied to determine what constitutes the business of insurance under the McCarran-Ferguson Act: they have the effect of transferring or spreading a policyholder's risk; they regulate an integral part of the policy relationship between the insurer and insured; and they are limited

to entities within the insurance industry. First, they are part of New York's regulatory effort to spread and distribute the risk of providing health insurance coverage. The 13% differential, between insurers who practice open enrollment and community rating and other insurers, benefits the insurers with the broader risk pools for the higher costs associated with insuring the poorer risks who, but for these practices, might be uninsured. It also allows them to continue to provide health care coverage at affordable prices to attract a large pool of varying risks. The 11% surcharge was intended to provide a benefit to Blue Cross vis-a-vis commercial insurance companies in order to stem the loss of low-risk subscribers from the Blue Cross risk pools, thereby allowing Blue Cross to maintain a mix of low, average and high risk subscribers. Thus, both the 13% differential and 11% surcharge spread risk.

The 13% differential and 11% surcharge also meet the second *Pireno* factor, albeit indirectly, by encouraging community rating and open enrollment. Community rating and open enrollment unquestionably play an integral role in the policy relationship between the insurer and the insured, by ensuring the formation of a policy relationship regardless of age, sex, health or occupational status and by determining that the price will be the same for all subscribers. Matters affecting the policy relationship between an insurer and the insured are not limited to the explicit terms contained in the insurance contract but extend to matters more broadly implicating the control of the business of insurance. *United States Department of Treasury v. Fabe*, 113 S.Ct. at 2209. In *Fabe*, the Court held that an Ohio liquidation statute which gave policyholders' claims a preference in the dissolution of a bankrupt insurance carrier affected the policy relationship between an insurer and the insured since it related to the ultimate performance of the contract in the event of liquidation. *Id.* In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir.), *cert. denied*, 114 S. Ct. 597 (1993), the Fourth Circuit held that a Virginia law which regulated an insurance company's selection of providers to be included in a preferred provider plan met the second *Pireno* factor since the choice of a provider was related to treatment and cost which are important components of

health insurance. *Id.* at 503. Similarly, the differential and the surcharge are designed to ensure that health insurance policies are accessible and affordable to New Yorkers. They are integral to whether policyholders will receive insurance, from which carriers and at what price. Those factors are an integral part of the policy relationship between the insured and insurer.

Finally, the differential and the surcharge are limited to entities in the insurance industry. The 11% surcharge was limited to commercial insurers. The 13% differential is, in effect, a discount. All third-party payors of hospital bills, except those with open enrollment and community rating, pay 113% of the DRG rate. All third-party payors of hospital bills are acting as insurers of patients. The fact that the insurance marketplace may involve hospitals, patients and others does not make the differential and the surcharge any less limited, since the determining factor is the insurers' role in the insurance marketplace.

CONCLUSION

For the reasons set forth, the Court should reverse the judgment below.

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Respectfully submitted,

G. OLIVER KOPPELL
Attorney General of the
State of New York
Attorney for Petitioners
Mario M. Cuomo, et al.
120 Broadway
New York, New York 10271
(212) 416-8707

JERRY BOONE
Solicitor General

ANDREA GREEN
Deputy Solicitor General

JANE LAUER BARKER
Assistant Attorney General
In Charge of Labor Bureau

M. PATRICIA SMITH*
Assistant Attorney General

*Counsel of Record